Violation & Denial of Access to Health-rights for Women Involved in Commercial Sex Work in Bangladesh

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As a marginalized group with no legal recognition and inadequate protection, the rights of commercial sex workers in Bangladesh are often violated. As commercial sex work has a detrimental impact on women’s health, this paper examines the health problems and diseases that commercial sex workers suffer from, the assistance and services available to them and their ability to access them. Analyzing these issues through focus group discussions and interviews, the paper identifies causes of the violation and denial of access to health rights for commercial sex workers. The paper recommends measures the various stakeholders need to take in order to improve the situation of the girls and women who are trapped in a heartless and abusive environment without economic or social support.

Bangladesh - Past & Present

Due to the partition of South Asia into India and Pakistan, modern Bangladesh was originally known as East Pakistan from 1947 until its independence in 1971. For the partition, South Asia was divided along religious lines. On the northwest side of India, Pakistan was formed for the Muslim majority and on the northeast side of India, East Bengal, also with a Muslim majority population, was also designated as a part of Pakistan. This partitioning was less than desirable since the two areas differed significantly in terms of language, culture, environment and economy. Moreover, they were more than 1,000 miles removed from each other, separated by the newly founded India (Kamal, 1989). For Bangladesh, the period from the partitioning in 1947 to the declaration of independence in 1971 was one of political suffering, economic degradation and constant struggle for identity against the dominant political elite in Pakistan. Having its political, economic and social interests mostly ignored, the populace of East Pakistan was largely left out of the political processes, decision-making and economic development. The subjugation of the Bengali culture by Pakistan and the frequent use of repressive measures against the Bengalis aggravated matters further. Eventually, this repression led to the launching of an independence movement for regional autonomy of East Pakistan by the Bengali intellectual and political elite (Ahmed, 1992). Continued repression, particularly attempts to rid the Bengalis of their own language and culture as well as the mass persecution of intellectuals, resulted in a fierce war for independence that begun on March 25, 1971. Having suffered what can be seen as a brutal deprivation in all spheres of life for almost 25 years, the people of Bangladesh fought hard for their independence (Mohsin & Islam, 1992).

The 23 years of Pakistanie rule were marked by long-term disparity that resulted from the unilateral extraction of economic and financial resources of Bangladesh. In essence, the newly independent state was a country stripped of almost everything of value. Having a largely agrarian economy alongside some rudimentary industry, Bangladesh continues to struggle to overcome its economic vulnerabilities. After 33 years of independence, Bangladesh is still one of the world’s poorest countries outside of Africa. Bangladesh’s population is approaching 140 million, and almost half of the population lives below the national poverty line. In fact, 36% of the Bangladeshis survive on less than $1 (U.S.) per day (United Nations Development Programme, 2005). Poor health facilities and standards as well as low education levels combined with a low per capita GDP of $361 (U.S.) are reflected in an average life expectancy of 61 years for men and women (Bangladesh Bureau of Statistics, 2005). At the onset of the 21st century, Bangladesh’s future is uncertain. Gendered discrepancies also abound. Although there are plenty of prospects and initiatives driven by the civil society and through the international donors, school enrollment rates that are only slightly more than 50% for men and women and literacy rates of 50.3% for men and 31.4% for women show that much work is left in closing the gender gap. Helping the poor to meet their daily needs of shelter, food, clothing, education, and healthcare pose mammoth challenges (United Nations Development Program, 2005).

Commercial Sex Work in Bangladesh

Although commercial sex work is a profession that has existed for centuries, many societies have either attempted to simply deny, hide its existence or have not been able to deal with it in clearly defined terms. For example, the Decennial Census of India conducted in the early nineteenth century categorized sex workers as non-agricultural, unskilled labor. The
1991 national census conducted by the Government of Bangladesh (GoB) categorized commercial sex workers as beggars and vagrants under the subheading of miscellaneous (Noorani, 2000). In Bangladesh, no legislation has been passed since independence (1971) that recognizes commercial sex as a profession. Furthermore, the society considers sex workers as fallen women who do not deserve social dignity or recognition. As a result, every person involved in the profession has become a victim of social exclusion and marginalization.

Categories of commercial sex workers tend to be defined by their workplace or setting (CARE Bangladesh, 1998). This paper focuses specifically on brothel-based, street-based, and hotel-based workers and examines their socio-economic status, health and hygienic practices, types of health problems and diseases most likely to afflict them, their treatment-seeking behavior and the types of health-related assistance available. Analyzing these issues through focus group discussions and interviews, the paper identifies the causes of the violation and denial of access to health rights for women involved in the commercial sex profession.

**METHODOLOGY**

In the current study, a number of methods were followed. First, an extensive review of literature from different organizations with programs for sex workers, particularly related to health issues, was undertaken. Second, during February and March 2005, interviews were held in Dhaka and Khulna with the secretary of an informal network of sex workers and with gynecologists from the Marie Stopes Clinic Society (MSCS) and the Dhaka Medical College Hospital. The interview with the secretary of sex worker's network focused on the socio-economic conditions of sex workers, and their suffering resulting from social stigma, violations of their health rights and the denial of access to healthcare services. Interviews also inquired about possible solutions to these problems. Gynecologists were questioned about the diseases and ill-health that sex workers suffer and the types of healthcare services that are available to them. As part of the organizational learning process, separate interviews were held with MSCS’s project manager in Khulna and with CARE Bangladesh’s technical coordinator for its HIV/AIDS program in Dhaka. They were individually asked about their program’s focus on the workers’ health rights and their ways of working toward making public service providers accountable.

During the same period, two focus group discussions (FGDs) were organized. One was held with six brothel-based sex workers in Khulna District, in the southwestern part of Bangladesh, and the second one was held with 10 street and hotel-based sex workers in Dhaka. The FGDs were organized to hear from the workers themselves about their socio-economic conditions, health related suffering, health and hygiene conditions, treatment-seeking behavior, birth control usage and how they were treated by healthcare service providers, brothel or hotel owners and other stakeholders.

**FINDINGS**

*Commercial Sex Work as a Profession in Bangladesh*

According to estimates made by different non-governmental organizations, there are over 150,000 girls and women involved in commercial sex work. The Government statistics, however, only acknowledge 9,000 sex workers (Noorani, 2000). As there are a total of 14 brothels in the entire country, a significant number of women do not live in brothels, but pursue their work under the guise of other professions, such as garment industry workers, beauticians, or masseuses. Although they engage in commercial sex work, none of these women are included in the Governmental statistics.

A number of local organizations, such as UBINIG, Jagrata Juba Shangha, Society for Environment and Human Development, have conducted studies to identify the factors that lead women to become commercial sex workers. Poverty, low household income, large family size, parents’ inability to pay dowry, high costs of arranging a daughter’s marriage and lack of educational and employment opportunities cause girls and women from poor families to become victims of trafficking and to take up commercial sex work. A network of brokers and middlemen exists throughout Bangladesh who entices girls and women from poor families with the promise of lucrative jobs, but sell them either to traffickers or directly to brothels (UBING, 1995). Upon being sold, women are frequently raped, first, to break their spirit and second, to prevent their return to their family. According to customs, a daughter or daughter-in-law who is sold into a brothel or raped will lose her social acceptance, rendering her family unable to accept her back into their home. Families fear social ostracism if they help a sex worker daughter or a wife. Thus, left without choices, girls and women resign themselves to a life of commercial sex work. There are also a large number of divorced, separated and abandoned women who try to support their family and children through commercial sex work (Jagrata Juba Shangha, 2001).
Categories of Sex Workers

Different categories of sex workers work in Bangladesh. Most workers are female, although there are also a small number of male sex workers (CARE Bangladesh, 1998). Those workers who are brothel-based have their clients come to them. Others work out of hotels and usually have their clients arranged for them through agents or hotel employees and owners. Sex workers are also found in beauty and massage parlors, though the street-based sex worker is the most visible category of all sex workers. A smaller number of women who have their clients arranged through agents are based in apartments or privately owned residences. These women tend to live in the more affluent areas and are considered upper-class sex workers. They often entertain wealthy customers such as businessmen, politicians and television and film actors.

Previously, sex workers could only be found in brothels. However, the forced closure of a number of brothels in recent years, the lack of established opportunities, poverty, lack of education and employment opportunities and mass migration to urban centers have all contributed to the explosion of hotel-based, home-based and street-based sex work. Street-based sex workers are considered as the lowest among all sex workers and no actual statistics about the number of these workers are available (CARE Bangladesh, 1998). According to the informal network of sex workers, there are about five or six thousand street-based sex workers in the capital city of Dhaka.

Socio-economic Status of Sex Workers

A report by Government of Bangladesh’s Ministry of Law, Justice and Parliamentary Affairs (cited in Human Rights Watch, 2003) states that “prostitution by an adult woman (above eighteen) is not prohibited by any law. But the Dhaka Metropolitan Police Act prohibits soliciting another person in the public for the purpose of prostitution, and therefore renders at least some forms of street-based sex works illegal.” This contradictory provision is repeated in the metropolitan police acts of the other five divisional towns in Bangladesh (Human Rights Watch, 2003). A second law, the Suppression of Immoral Traffic Act (SITA), makes the ownership or management of a brothel or the buying, selling, or living off of prostitutes illegal, although it does not criminalize the sex workers themselves (Human Rights Watch, 2003). Thus, without legal protection under Bangladeshi law, girls and women involved in this profession have to struggle daily for their survival. A woman's daily income depends on her sex worker category, class, status, and physical appearance and may be as low as 50¢ (U.S.), or as high as about $33 (U.S.). Other than sex workers based in residential areas, all other types of sex workers are economically vulnerable.

In every brothel, there is at least one female owner called sardarni. In most brothels, there is more than one sardarni. Sardarnis, themselves are retired sex workers who have gone through the same abuse and exploitation by their respective owners. Generally, sex workers can earn an income well into their mid-thirties, though only a few can accumulate an alternative income for after retirement. Rejected by society, a few of the previous sex workers continue to manage brothels. In a vicious cycle, they earn an income through procuring and exploiting the younger women. In fact, all sex workers dream of becoming a sardarni some day. They try to save as much as they can to realize this dream, though only a few can actually realize the dream. Only those workers who can save some of their earnings in their young age are able to move into a sardarni position. As these few women eventually come to possess adequate resources, poorer men willingly marry and stay with them, passing their time in leisure or pursuing illegal businesses, often using their wife’s earnings. Police, pimps and other middlemen maintain good relationships with them, as the sardarni is the only person in a brothel who provides them with bribes (Tahmina & Moral, 2004).

Adolescent girls have to work at least four to five years as bonded sex workers under their sardarni. Often, they are illegally purchased by the sardarni when they are below 18 years of age. Neither written nor verbal agreements exist between the adolescent girls and their sardarni concerning the duration of their servitude. As long as the girls and women remain in the brothel under the sardarni, they have no control over their income and their entire earnings have to be handed over each day to their owner. The girls themselves only receive food and accommodation while they are often forced to entertain a large number of clients, thereby earning substantial sums for the owner. The sardarni herself decides how many customers each girl will entertain regardless of her physical condition. They are required to entertain clients even when they are ill, putting at risk both themselves and their clients (Tahmina & Moral, 2004). Salma, a bonded sex worker in Banashanta brothel in Khulna, said that she was only allowed two days of rest after her first abortion (personal interview, February 13, 2005).

After three or four years of bonded sex labor, the women come to realize that their owner has long ago recovered the amount spent for their purchase and has earned substantial profit through their labor. As a consequence of this realization, many women attempt to empower themselves and some manage to free themselves of their bondage. However, the move for freedom often causes bitter and sometimes even
bloody fights with the sardarni and the girls seek the help of a customer to intervene and negotiate with the sardarni on their behalf. Sometimes NGOs working inside brothels help the girls fight back. In most cases, the sardarni ultimately accepts her defeat (Tahmina & Moral, 2004). However, once freed from servitude, the sardarni begins to charge the women at least $5 (U.S.) daily for accommodation while the girls still have to arrange for their own food.

Hotel-based sex workers are completely at the mercy of the hotel owners, as they depend on them for their customers. For each customer, women only receive one-third of the fee paid by the client, of which she has to pay one-fourth for her food cost.

Since street-based sex workers have no established or fixed places to engage in their work, they are considered floating prostitutes. They live in slums or the poorer areas of different cities and move around the streets to earn their livelihood. Most of their clients are from the low-income group and pay as little as they can. During the daytime, it is very difficult for street-based sex workers to find any place with some privacy where they can pursue their profession. Most customers come during the evening or at night. Their total earnings are negligible and the street-based sex workers therefore earn the least income of all sex workers. During lean periods, such as winter or on rainy days, they often have to survive on less than 50¢. Regardless of the amount earned, sex workers have to pay house rent or face eviction. If they have children, they also have to pay for their children's food, education-related costs and other household expenditures. In many cases, they also have to feed some old women they retain who take care of their children while they work. These old women themselves are former sex workers who can no longer work and are left without any income.

Many impoverished parents and siblings of sex workers maintain secret communication and contact with them in order to receive financial assistance from them. Relationships are kept secret due to the parents' and siblings' fear of social ostracism. Supporting their parents and younger siblings is another burden for the sex workers who already have to pay regular bribes to the police, brokers and other middlemen.

The social status of sex workers in Bangladesh is considered so low that in the past, they were neither allowed to wear shoes/sandals when leaving the brothel nor allowed to wear the typical shalwar-kameez dress worn by adolescent girls and unmarried women. Preventing sex workers from wearing sandals and shalwar-kameez enables society to easily identify the girls and women involved in the sex trade, to ostracize them and to treat them as a stigmatized group. To counter the historic stigmatization, some NGOs in Bangladesh have been implementing different types of programs for sex workers. For example, ActionAid Bangladesh works to enroll their children in primary schools, the Bangladesh National Women’s Lawyers’ Association provides them with free legal assistance, CARE Bangladesh provides means for prevention of HIV/AIDS and facilitates the self-help organization of sex workers and the United Nations Development Programme, in collaboration with the Government, provides awareness and counseling on human rights, small scale healthcare support and awareness programs on prevention of HIV/AIDS and STDs.

Despite these positive programs, most sex workers still find it difficult to access public services, such as education and healthcare. They also have a hard time in switching to other types of income-generating activities. Children of commercial sex workers are not able to enroll in public schools and study together with other children, because in Bangladesh, mothers cannot claim guardianship of their children without disclosing the father’s identity. If a sex worker goes to a hospital for treatment and is identified as a sex worker, medical professionals will either humiliate her or refuse to examine and treat her or overcharge her.

Even death fails to end the sex workers’ misery. Regardless of whether a sex worker is Hindu, Muslim, or Christian, she is still denied basic funeral rites (Nooran, 2000). In Bangladesh, a country dissected by hundreds of rivers, most brothels are established next to rivers; when a sex worker passes away, her body is simply discarded into the river, as no cemetery or cremation ghat would allow her to buried or cremated there.

Hotel and street-based sex workers suffer the most violence and abuse from the police and from mastans, muscle men often employed by local politicians to extort tolls from businesses and others such as sex workers. Without legal protection of their profession, these sex workers are often arrested and harassed for bribes and are even forced to have sex with police officials or are gang raped by the mastans. Jahan, a hotel-based sex worker, said that she was abducted and was retained for 48 hours by a police officer who repeatedly beat her up and raped her (Human Rights Watch, 2003).

Although there are no official statistics, murders of sex workers occur as well. In most cases, victims are hotel or street-based sex workers, their murdered bodies found in a park or a hotel. Usually, families do not come forward to claim the body as no one wants to admit they are related to a sex worker. Hotel owners do not want to come forward to file a case while fellow sex workers also keep silent fearing for their own safety. Without anyone coming forward, cases are hardly ever filed when a sex worker is murdered, even though the police have the authority to file such cases. Instead, everyone tries to conceal the identity of the victim. Brothel-based...
workers have somewhat more security than other workers, because when a murder takes place in a brothel, it does not remain secret. On the contrary, human rights organizations, women activists, journalists, and NGOs start a movement to compel the police to search and arrest the culprit, though they are not always successful.

**Health & Hygiene**

Regardless of where a sex worker is based, most need to entertain an average of eight to ten clients per day to earn the minimum amount needed for daily survival. However, most sex workers do not maintain proper hygienic practices after attending a client due to lack of knowledge concerning the need for proper hygienic practices and the potential risks associated with the absence of such practices. Furthermore, very limited access to showers and sanitary facilities forces even the somewhat enlightened sex workers to manage with a minimal amount of hygiene. In brothels where the water supply is inadequate, women suffer more as they have to pay an outside supplier for each bucket of water. As a result, most sex workers are not able to clean themselves more than two or three times per day, though they entertain a large number of clients.

Using the same bed-sheet and wearing the same dress to entertain several customers is very common. Sanitary facilities shared by a large number of workers are another obstacle to proper hygiene; about ten hotel-based workers, for example, share a single toilet. Hotels used for this purpose are often very cheap and have poor water supply in their bathing facilities. Hazera, a hotel-based sex worker said “generally I get a chance to clean only the genital area after entertaining three or four clients. As the hotel owner has only one toilet for 10 to 15 of us, there is always a long queue and nobody wants to lose customers by wasting time in the queue” (personal interview, March 2, 2005).

Street-based workers hardly even think about the importance of sanitary facilities, showers, or hygienic practices. Only a few street-based workers are able to rent a room where they sleep and where they can use sanitary latrines. Many workers cannot even afford a room. Instead, they sleep on sidewalks, in parks, railway stations, or building entrances, with no access to sanitary or shower facilities. They wander the city streets in search of clients to entertain in any available location, whether a public park, a cheap hotel or boarding house, a bazaar or market, or makeshift shelters commonly found near train stations. Nasima, a street-based sex worker said, “because money means survival, we never think about hygiene and cleanliness, but are ready to go any place” (personal interview, March 2, 2005).

**Illness & Disease: Reproductive Tract Infections (RTIs) & Sexually Transmitted Diseases (STDs)**

Due to the frequency of sexual contact and the significant number of clients entertained each day, commercial sex workers are at great risk of contracting STDs or RTIs. Though the use of condoms, especially for commercial sex workers has been advocated for more than a decade by a number of NGOs, actual utilization is still insignificant. In many cases, it is the customers who refuse to use condoms even when asked to do so by the workers. In other cases, sex workers are already using some form of birth control and therefore feel that using a condom is not important. The workers’ vulnerability and risk of contracting STDs thereby increases greatly. Most sex workers simultaneously have a number of symptoms of STDs and RTIs, such as vaginal discharge, cervical discharge, swelling over the groin, excessive white discharge, burning sensation during urination, or painful recurring superficial ulcers on the vulva. In some cases, these symptoms are caused by the onset of syphilis and gonorrhea, the long-term consequences of which can be sterility, deep dyspareunia and cervical cancer. Sex workers in Bangladesh, however, are also very much at risk of getting infected by hepatitis B and C, the treatment for which they usually cannot afford.

Although the infection rate of HIV/AIDS among the total population in Bangladesh is still very small, the commercial sex workers’ risk of being infected is considered to be significant. Both NGOs and donors have started awareness campaigns on safe-sex practices, promotion of condom use, and even blood-test screening to detect the sex workers who are already infected with HIV/AIDS. Nevertheless, the infection rate of RTIs and STDs is slowly spreading into the general population. A gynecologist of the Dhaka Medical College Hospital who was interviewed said that she is finding higher numbers of housewives who are found to have RTIs or STDs when they come for ante-natal checkups or for child delivery. In most cases, these women are wives of migrant workers or long distance truck drivers who spend long periods of time away from home and visit commercial sex workers from whom they get infected. When they return home for brief visits with their families, they pass the disease on to their wives (personal interview, February 24, 2005).

**Effects of Birth Control Methods**

As most sex workers carry out their work during childbearing ages, many use different types of contraceptive methods. The majority begins by taking birth control pills without having a doctor’s prescription. Instead, they purchase a cheap brand openly available at a pharmacy. However, most girls/women soon experience severe side effects, such as
headaches, abdominal pain and general weakness. After a while, most workers switch to either a Depot injection or a Copper-t/Intra-Uterine Device (IUD) and a small number get implanted with Norplant (Deo, 1999; personal interview, March 2, 2005).

As most workers have very limited access to proper health services, they receive the Depot injection or Copper-t/IUD from unregistered physicians, unskilled nurses, or substandard health workers. There is, therefore, no opportunity for a hormonal test, which would detect the most appropriate method for a particular woman. Once the injection has been given, the women also have no recourse in case it causes side effects. In many cases, women complain from weight gain, muscle pain and burning sensations in the palm of the hand and the sole of the feet. The majority of women experience an incessant burning sensation inside the vagina, infections inside the uterus and dramatic irregularity and increases in their menstrual cycles. In some cases, displacement of the Copper-t/IUD causes serious internal hemorrhage leading to perforation of the uterus.

Suffering Related to Abortion, Pregnancy & Other Gynecological Complications

Many sex workers are vulnerable to conception as they face numerous difficulties with the various types of birth control methods and because most of their customers prefer to have unprotected intercourse. The only solution for a sex worker who is impregnated by chance and does not want to have the child is to have a menstrual regulation (MR) performed. MR is a form of abortion “where, under anesthesia, the cervix is gently dilated with the help of an instrument and the contents of the uterus are evacuated either with the help of a suction apparatus or through instruments” (Web Health Centre, 2005). This is similar to the dilation and curettage form of abortion, though in a DNC, the uterus is gently dilated with the help of an instrument and the contents of the uterus are evacuated either with the help of a suction apparatus or through instruments.

Frequent performance of MRs is common among commercial sex workers. Some sex workers have MRs performed two or three times per year, which causes excessive bleeding and weakness and leaves them in ill health. Although performing MRs is not legal in Bangladesh, registered medical professionals and hospitals are allowed to perform an MR in emergencies or in case of pregnancy complications within six weeks of conception. Although medical professionals strongly discourage MRs after six weeks of pregnancy due to the potential health risks involved for the mother, many sex workers have MRs performed up to twelve weeks after conception and in some cases even later. The focus group discussions revealed that both brothel and street-based sex workers have abortions performed even after eight months of pregnancy, subjecting the workers to a high morbidity and mortality risk. Amena, a brothel-based sex worker said that “in 2003, I became pregnant and one of my regular customers told me that he would stand by me and support me if I keep the child. I decided to have the child, but in my seventh month of pregnancy, this man betrayed his promise and left me. To take revenge on him, I decided to have an abortion while my pregnancy was already in the eighth month. It caused me such a lot of pain and I was bedridden for three months and also had to spent a lot of money for my treatment” (personal interview, February 13, 2005).

As the materials required performing MRs and abortions are openly available in the market, they are easily and precariously performed by local, unregistered medical professionals, unskilled nurses, or unregistered clinics providing cheap, unprofessional services. As a result, the occurrence of incomplete MRs, causing excessive bleeding, infection, perforation of the uterus and other health complications, is high.

Pregnancy and childbearing is never a pleasant experience for women involved in the commercial sex profession. Moreover, no man will admit or accept fatherhood of a child born to a sex worker. In the social and cultural context of Bangladesh, it is very difficult for a single mother to raise her children, to enroll them in school and to be able to arrange the marriage of girls. As pregnant sex workers receive no financial or other support and are completely dependent on them, pregnancy does not bring about any changes in their living patterns. They still have to pursue the daily task of searching for and entertaining clients. Consumption of a balanced and nutritious diet is impossible, as workers are able to attract fewer clients during their pregnancy. Faced with financial constraints, pre and post-natal checkups are luxuries that no sex worker can afford.

If a pregnancy is allowed to reach completion, a traditional birth attendant (TBA) is the most likely one to perform the delivery. Of course, it is very difficult to find a trained and qualified TBA in most urban and rural areas. As many women end up using the services of untrained TBAs, delays before and complications during delivery are frequent, often causing unbearable sufferings to the women. Permanent disabilities as well as the death of the newborn are frequent. A quick recovery is often prevented by the malnourished state of the workers.

The necessity of earnings to purchase food stuffs and to meet other basic needs combined with a lack of alternative livelihood options, force women to disregard caution for their own health. Most sex workers entertain customers in the late stages of pregnancy or soon after an abortion or an MR. Nazma, a street-based sex worker, mentioned during an interview that she went to work only three days after having an MR performed. The secretary of the informal network of sex workers
mentioned that a woman named Jamila from her neighboring area attended a customer the night before giving birth (personal Interview, March 2, 2005). The consequences of these precarious behaviors, albeit due to sheer necessity, are excessive bleeding and sudden abortions. These risky practices can even lead to cervical cancer. The sex workers’ group also mentioned that, in the recent years, the incidence rate of uterus tumors has become very high.

*Healthcare & Treatment-Seeking Behavior*

Their poor economic condition and marginalized social status leaves commercial sex workers’ health vulnerable and they are less likely to seek appropriate and timely health services. Moreover, negative attitudes and unprofessional behavior by healthcare providers discourages them from availing themselves of public or private health services. However, the probability of becoming bedridden and losing the ability to seek out and entertain clients is significant. Fuelled by the fear of long-term disabling diseases, treatment is quickly sought for general illnesses such as fevers, headaches and coughing, as medication is readily available from pharmacies or local doctors. Ironically, sex workers do not consider symptoms related to STDs, such as vaginal discharge, itching and irritation in and around the vaginal area, abdominal pain and burning sensation while urinating serious enough to seek immediate treatment. The vast majority of women will wait until these symptoms become unbearable before doing anything about them. Sex workers revealed during the FGDs that they consider their vagina to be little more than a tool with which they earn their livelihood and hence are willing to accept any physical irritation or other complicacies. Nahar, a street-based sex worker said that “our bodies are like machines for making money and we have to run these machines until they break” (Focus Group Discussion, March 3, 2005).

As a result of the recent NGO and donor implemented HIV/AIDS campaigns, sex workers have gained significant awareness about the effects of HIV/AIDS and about the use of preventive measures. In comparison, their knowledge on the frequent performance of MRs or abortions remains very poor (Tahmina & Moral, 2004). They hardly consider the potential risks of having MRs performed by unregistered doctors or clinics and in worst case scenarios, commercial sex workers may decide to perform an MR or an abortion on themselves, either by self-medication of over-using birth control pills or by inserting noxious herbal roots inside their uterus.

*Types of Assistance Provided by Various Service Providers*

**Role of Unregistered Doctors & Clinics:** Unregistered doctors and clinic owners without academic or professional training and degrees usually start their businesses in the vicinity of brothels, slums and other areas frequented by commercial sex workers with the sole objective of taking advantage of women’s vulnerability. So-called doctors, hardly more than quacks, visit brothels to sell their medical services. The services range from general health exams to treatment for STDs and RTIs. If a woman requires an MR or an abortion, these doctors will bring the necessary materials to the brothels or the worker’s home and perform the operation in the unhygienic setting, usually on the woman’s bed.

As most of the girls and women are uneducated, they rarely inquire about the qualification of the doctors. Neither do they question the possibility of being taken advantage of. Women’s ignorance and desperation and the doctor’s easy accessibility and affordability combine to create a pattern of dependency. Women’s ignorance leaves them vulnerable to further abuse. To increase their profits, doctors frequently start the women on low dosages of medication so that the patients are forced to return to them. To treat a woman for STDs, a doctor may prescribe a general antibiotic or only a painkiller. After using the medicine two or three times without seeing any improvement in her condition, the woman may seek out another doctor, hoping that she will not be taken advantage of again. These shifts rarely reduce women’s victimization.

In most of Bangladesh’s larger cities, a number of shady clinics have sprung up, avoiding visibility, hiding themselves in side streets. Though their appearance and advertisement leads the sex workers to believe that professional gynecologists operate them, they are in fact run by some nurses and birth attendants who provide sub-standard medical services at a minimum cost. In hope of receiving better treatment, many women will come to the clinics to have MRs and abortions performed or to give birth. Since the clinics’ staff are not medical doctors, medical accidents are frequent. Women face many complications from the poor service they receive.

None of the doctors or clinic operators will take responsibility for any negative consequence or side effects caused by their treatment, abortions or MRs they perform. As a last resort, sick women may have to go to the larger medical colleges and hospitals or visit expensive private clinics. For these last-resort measures, they often have to spend their entire life’s savings. Some may have to borrow money from fellow sex workers, which also increase the pressures on their lives.
Role of Brothel Owners, Hotel Owners & Middlemen

Brothel and hotel owners and middlemen make the greatest profit from the commercial sex industry. Unfortunately, they are also the least concerned about the women’s health status. If a girl or woman is working as a bonded sex worker and is forced to hand over her entire earnings to the brothel or hotel owner, she may receive some medicine from the owner, despite the fact that the quality and efficacy of such medication is questionable. Once the women free themselves from their servitude, they will no longer receive any help or medicine from the owner. Regardless of ill health, they still will have to pay the daily room rent and other regular expenses. A woman’s inability to pay for her medication will leave her in debt, which she must repay as soon as possible. Long illnesses and the inability to work are likely to lead to a woman’s eviction from the brothel.

Sulekha, a hotel-based sex worker, said that “if any woman starts to feel physically ill after, for example, entertaining two or three customers, the owner will tell her to stop work and leave the hotel. If the amount she has earned from the customers she has entertained up to that point is less than the amount charged by the owner for her room, she will have to leave without any money for that day and hope that the hotel owner will provide her with a small amount for her transportation back home” (Focus Group Discussion, March 3, 2005).

Since owners depend on sex workers for their income and stand to lose significantly if workers seek their rights, the hotel and brothel owners and the middlemen resist and discourage any attempt by commercial sex workers to organize themselves. Furthermore, although they are deeply involved in the sex industry, the owners and middlemen hide their involvement from the outside world for fear of being socially excluded themselves. Thus, sex work remains a dark and dangerous industry, especially for the workers.

Role of NGOs & Other Organizations: The Marie Stopes Clinic Society (MSCS) is a registered NGO in Bangladesh that is affiliated with Marie Stopes International, registered in the United Kingdom. It is a non-profit organization funded in part by the Overseas Development Agency (ODA), the European Union and Marie Stopes International (MSI). The MSCS clinics in Bangladesh provide health and medical services, including family planning, pre-natal and post-natal care, immunization, treatment of RTIs and STDs. They also provide medicine. All services and medicines are provided at subsidized rates for clients who cannot afford the regular prices. The MSCS started two satellite clinics at brothels close to Mongla and Bagerhat, two cities in Khulna Division in southwestern Bangladesh. The Mongla satellite clinic initially operated two days a week and the Bagerhat satellite clinic for one day a week. Unfortunately, due to funding constraints, the Mongla satellite clinic now operates only two days a month while the Bagerhat satellite clinic is open only one day per month. These satellite clinics provide consultation on RTIs and STDs, diagnosis, low cost treatment, as well as provide medicine for RTIs and STDs at subsidized rates. They even perform MRs at a minimal cost of $1.50 (U.S.). If sex workers cannot even afford the subsidized rate, they only receive the prescription and have to purchase the medicine from an independent pharmacy at the commercial rate. Most other reproductive services, such as pre-natal and post-natal care, or family planning, are referred to regular clinics.

According to the sex workers, sometimes it is cheaper for them to purchase medicines directly from their local pharmacy or doctor rather than through the MSCS satellite clinics. The MSCS clinic staff, on the other hand, report that the sex workers do not want the trouble of crossing the river just to avail themselves of the referral services. They seem to prefer to have MRs performed by less qualified service providers who are found nearby.

When Care Bangladesh first initiated its HIV/AIDS prevention program in the mid-1990s, it was found that the HIV/AIDS prevalence rate was less than 1% among commercial sex workers. The organization decided on multi-pronged approach and immediately started an HIV prevention and awareness campaign among the commercial sex workers, disseminating information on the role of STDs in prevention of HIV and advocating the use of condoms and providing them as well. Some sex workers were selected to work as peer educators to provide knowledge for the prevention of HIV through safe sex practices to their fellow sex workers and to mobilize them to seek treatment if infected. Second, CARE Bangladesh targeted brothel owners, middlemen and customers and provided them with information on prevention of HIV/AIDS and other STDs. Third, they started to make treatment for STDs available within brothel areas. A clinic was established in Tangail, a city north of Dhaka, to provide early detection of and treatment for STDs. A drop-in center was established in Dhaka where the street-based sex workers can come to use the toilet, take a shower and stay to get some rest. A satellite clinic was started within the drop-in center where sex workers were ensured of confidentiality (CARE Bangladesh, 2004).

After gathering experience for a few years, CARE Bangladesh realized that providing awareness and prevention services on HIV and STD to only two or three smaller areas will not be sufficient to reach the larger target population, itself scattered all over the city as well as the outlying towns. CARE Bangladesh then started to mobilize public service providers seeking to change their attitude and behavior toward the
marginalized women, to reduce all forms of discrimination against them and to have the providers agree to maintain proper confidentiality for each patient.

Finally, CARE Bangladesh realized that the only way to overcome the negative social attitudes toward sex workers was to work with the sex workers on their human rights. CARE Bangladesh began to mobilize groups of sex workers across the country, encouraging and assisting them to organize themselves in order to create a platform calling on them to resit the violation and denial of their human rights (CARE Bangladesh, 2004).

Since 1998, three other NGOs, namely Durjoy Nari Shangha (United Brave Women), Nari Mukti Shangha (United Women’s Freedom) and Ulka (Shooting Star) were started by sex workers as self-help groups and to build alliances with other similar organizations. Their efforts led to the creation of an informal network of sex workers in 2002, which has come to play a vital role in advocating their human rights.

Role of Public Service Providers: According to the Bangladeshi Government’s public health policy, treatment for STDs is available at all government-operated healthcare centers. The Government has established a national AIDS committee to conduct a continuous awareness campaign through various media to disseminate information on prevention of STDs and HIV infection and to operate control programs. Under the control programs, six HIV testing centers have been established as well as a blood donor screening program for STDs, Hepatitis B, and HIV. Departments of Dermatology and Sexually Transmitted Diseases were started at all district-level hospitals to provide STD and RTI related services for all. Most of the hospitals, especially those outside Dhaka, however, are either under-equipped or understaffed to provide these services properly.

Even though the government services are of a better quality than those offered by local doctors or clinics, sex workers largely choose not to avail themselves of the Government’s services. This reluctance has many reasons. First, the doctors at government hospitals and clinics tend to be judgmental and they frequently insult the women whom they easily recognize as sex workers. Short of refusing to treat them, they nevertheless make them feel unwanted and tell them that their diseases and illnesses are the result of the “sins” they have committed. As privacy is a given concern for the sex workers, they mistrust the doctors from whom they know not to expect any respect or confidentiality. Second, as most sex workers are not able to practice proper hygiene, other patients also discriminate against them and shun them. They refuse to accept a sex worker in their wards.

Government doctors, on the other hand, blame the sex workers themselves for their poor treatment-seeking behavior. According to the government-employed medical staff, sex workers always seek out unqualified doctors and clinics to have MRs, abortions, or birth deliveries performed and only when there are complications, do they come to the government hospitals in need of emergency medical services. Government doctors also insist on taking stringent precautions prior to treating a sex worker, which they feel they have to do to ensure the safety of other patients and to prevent the spread of infections of STDs. In large government hospitals, however, the doctors have too many patients to care for and will deny treatment to a sex worker if they feel they cannot protect their other patients.

Members of the sex workers’ informal network have taken on a vocal role to seek service reform from public providers and to assuage their attitudes toward these women. The network’s secretary shared that sex workers now feel more entitled to seek assistance from government hospitals in case of complicated cesarean-sections and operations. When a woman finds herself discriminated against, members of the network immediately mount a protest campaign against the offender. Still, not all categories of sex workers have been equally empowered to fight for their rights and many still suffer from discrimination and are lacking access to health-care rights.

**IS A SAFER & HEALTHIER FUTURE POSSIBLE FOR COMMERCIAL SEX WORKERS?**

Bangladesh became a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and ratified it in 1984, though with reservations (Ahmed, 2002). As a signatory of CEDAW, the Government of Bangladesh is obliged to follow Article 6, according to which “states parties shall take appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women” and to which it has no reservations (Bangladesh Mahila Parishad, Bangladesh National Women Lawyers Association, Naripokkho, 1997, p. 3). Although the Government has ratified the treaty, no steps have been taken to provide health, sanitation and education services for sex workers and their families. Law enforcement agencies who are supposed to treat sex workers like normal citizen, to protect their rights under the laws equally, for example in the case of rape, discriminate against them. Sometimes, they even become the perpetrators of crimes against them such as rape of sex workers by some police.
The analysis of the current situation makes it clear that the main cause of the commercial sex workers' numerous sufferings is the position accorded to them by society and its members. To ensure their health rights, first ensuring their human rights is an absolute prerequisite. At minimum, this requires for the sex work profession to be legally recognized by the Government.

Public health service providers need to be sensitized not to judge sex workers simply for who they are and what they do, but rather, treat women as human beings and provide them with the medical services they require. Medical professionals need to be sensitive toward the workers’ need for privacy and confidentiality, particularly respecting the privacy of women suffering from STDs or HIV/AIDS. Government hospitals need to be better equipped and staffed by specialized doctors. Specialists need to treat workers, either with STDs or suffering from other diseases, in a professional manner. Providing sex workers with opportunities for blood screening will dispel the doctors’ fear of contracting STDs or HIV/AIDS during treatment. Accountability by service providers needs to be ensured so that those sex workers who are really infected can receive treatment. Also, their doctors need accurate information for developing the means to protect themselves.

Hotel and brothel owners, sardarni and middlemen who earn their living off the sex workers’ labor need to be pressured into giving the women some economic freedom. If the Government recognizes their legal protection and social inclusion, brothel and hotel owners can be required to provide the women with safe working conditions, proper sanitary facilities, and access to water, accommodation and food without being able to overcharge them for these basic provisions.

Most of the NGOs and donor agencies still focus singularly on the prevention of STDs and HIV/AIDS. They need to broaden their services to address the crucial need to educate all sex workers about the importance of proper hygiene, especially after entertaining a customer, the possible effects of various birth control methods and the long-term effects of repeated MRs and abortions. Sex workers need to be made aware of the dangers of seeking assistance from unskilled doctors and clinics in performing MRs and abortions. Special care needs to be ensured for sex workers during and after a pregnancy, particularly as a healthy and balanced diet, regular pre-natal check-ups, assistance from trained birth attendants during delivery, as well as post-natal care. Alternative livelihood options need to be identified. Interested NGOs may start to teach work-skills, to ensure that sex workers are not forced to entertain customers in advanced stages of pregnancy, soon after delivery, or after having an MR performed. Such alternatives also need to be provided, both by NGOs and the Government, for girls and women who want to leave the profession, but find they are facing a prejudicial society that is not willing to take them back and does not provide any choices for these women.

NGOs can mobilize all types of sex workers and unite them on one platform for collective action. The sex workers' platform can work with interested NGOs to provide skill training for sex workers to earn alternative livelihoods, so they can gradually reduce their involvement with the sex profession and even quit, if they so choose. The platform can urge donors to provide support not only for HIV/AIDS and STD awareness and prevention, but also for support for other reproductive health related illnesses. Finally, a sex workers’ platform can engage with the civil society to advocate for and take seriously the work of the public service providers. After all, the service providers are the ones accountable for and who take responsibility toward girls and women involved with the commercial sex profession.
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Patriarchal Pressures on Women's Freedom, Sexuality, Reproductive Health & Women's Co-optation into Their Own Subjugation

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Starting from the conceptualizations of patriarchal power, the present paper explores the destructive control of girls and women under classic patriarchies. Examples include female infanticide, Chinese foot-binding, dowry and bride-price systems, forced virginity tests, genital mutilation, honour killings and sati. Despite the myriad of its manifestations, it is argued that the unifying ingredient in all patriarchies is the obsessive control over women's freedom, sexuality and reproduction. What is also noteworthy is that patriarchal systems often co-opt women, especially older women, to become enforcers of the rules that bind younger women and girls. Borrowing Kandiyoti's term (1988), the co-optation is perceived as a “patriarchal bargain.” The paper ends by suggesting changes at the international, national, regional and local levels. It is argued that to end the patriarchal choke on women's lives, a human rights approach which binds the signatory states is very helpful but not enough. Simultaneously, both women's and men's expectations, behaviour and standard of life ought to be addressed.

Social scientists often define 'power as the ability to assert one's own will on others, regardless of the will of the others (Crosbie, 1975; Homans, 1974). This definition of power emphasizes the relational aspect of the term. One cannot have power in a vacuum, without also having someone or something to have power over. The above definition also makes it clear that power is dormant; that means, it lies within the 'ability' of the power holder. He (sic) may act on this ability and translate it into action, at which time power becomes influence. He may force others to subordinate to his will disregarding all strong objections, at which time it becomes 'coercive power.' Nevertheless, it is often the case that the power holder does not need to translate his ability into action or force. Instead, the more perceived power the power-holder has, the less the need to turn it into

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